

# Commentary

## Physician-Assisted Suicide Overview of the Ethical Debate

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Physician-assisted suicide and euthanasia are the subject of an ancient moral debate, the modern history of which has three distinct phases. In the first, it is primarily theologians who joust with one another. Second, philosophers and others weigh in and begin to make arguments, pro and con, in more secular fashion. In the third phase, the debate shifts to the arena of public policy.

### Theology

Forty or more years ago, the debate about physician-assisted suicide and euthanasia was dominated by theologians such as Joseph Fletcher, the Episcopalian liberal, and Paul Ramsey, the Presbyterian conservative. In the chapter "Euthanasia: Our Right to Die" of Fletcher's 1954 book, *Morals and Medicine*,<sup>1</sup> he begins by rebutting the traditional theological arguments against suicide. He then undertakes to refute, one by one, what he describes as "ten most common and most important objections" to euthanasia:

OBJECTION: Euthanasia, when voluntary, is really suicide.

FLETCHER: "personal integrity is a value worth the loss of life, especially since ... there is no hope of relief from the demoralizing pain and no further possibility of serving others."

OBJECTION: Euthanasia, when involuntary, is murder.

FLETCHER: "the motive and the end sought ... are entirely different in euthanasia from the motive and intent in murder, even though the means—taking life—happens to be the same."

OBJECTION: "God reserves ... the right to decide at what moment a life shall cease."

FLETCHER: "Prolonging life, on this divine-monopoly view, when a life appears to be ending through natural or physical causes, is just as much an interference with natural determinism as mercifully ending a life before physiology does it in its own amoral way. This argument that we must not tamper with life also assumes that physiological life is sacrosanct ... a form of vitalism ... which we reject."

OBJECTION: Euthanasia violates the Biblical command, "Thou shalt not kill."

FLETCHER: "Certainly those who justify war and capital punishment, as most Christians do, cannot condemn euthanasia on this ground."

OBJECTION: "suffering is a part of the divine plan for the good of [the human] soul, and must therefore be accepted."

FLETCHER: "Does this mean that the physicians' Hippocratic Oath is opposed to Christian virtue and doctrine? If this simple and naive idea of suffering were a valid one, then we should not be able to give our moral approval to anesthetics or to provide any medical relief of human suffering."

OBJECTION: Patients pronounced incurable might recover after all, for doctors can and do make mistakes.

FLETCHER: "This seems, frankly, like a fundamentally obstructionist argument. It [is] ... an evasion based on fallibility."

OBJECTION: patients racked by pain might make impulsive and ill-considered requests for euthanasia.

FLETCHER: "To this there are two rejoinders: first, that a careful law ... would provide that there must be medical advice that death is certain, which rules out any hasty euthanasia in non-fatal illnesses; and, second, that the law would provide an interval between application and administration."

OBJECTION: The moral and legal approval of euthanasia "would weaken our moral fiber, [and] tend to encourage us to minimize the importance of life."

FLETCHER: "It could just as easily be reasoned that to ask for euthanasia, to leave voluntarily for the unknown, would call for courage and resolution and faith, and would encourage us to live with faith and without fear."

OBJECTION: that the ethics of a physician forbids the taking of life.

FLETCHER: "We have already recognized that *as a fact*, but the issue is raised precisely because there are cases when the doctor's duty to prolong and protect life

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is in conflict with [the] equal duty to relieve suffering.”

**OBJECTION:** Doctors, while engaging in the practice, do not want euthanasia made legal.

**FLETCHER:** Fletcher counters this final argument with data, drawn from various surveys, showing that “a good many doctors feel ... that euthanasia ought to be legalized.”

Fletcher shows himself to be an ardent advocate of “voluntary medical euthanasia—as a means of ending a human life enmeshed in incurable and fatal physical suffering.”

Paul Ramsey countered Fletcher’s arguments in his 1970 book, *The Patient as Person: Explorations in Medical Ethics*, in a chapter entitled, “On (Only) Caring for the Dying.” Ramsey inveighed against two opposite extremes that can be summed up in Arthur Hugh Clough’s aphorism in *The Latest Decalogue*, “Thou shalt not kill; but need’st not strive/Officiously to keep alive.” This is how Ramsey expressed it: “One of these extremes is the medical and moral opinion that there is never any reason not to use or to stop using any and all life-sustaining procedures. The other extreme is that of those, including a few theological ethicists, who favor the adoption of active schemes of positive euthanasia which justify, under certain circumstances, the direct killing of terminal patients.” He subsequently criticizes Fletcher by name: “The fact that [Professor Joseph Fletcher] is himself a proponent of euthanasia ... has meant on his part a serious misunderstanding of the ethics of only attending the dying.” Ramsey strenuously insists that there is a moral distinction between what he calls acts of omission and acts of commission: “In omission no human agent causes the patient’s death, directly or indirectly. He dies his own death from causes that it is no longer merciful or reasonable to fight by means of possible medical interventions.” In commission, of course, the causal link between the action taken by the physician and the ensuing death of the patient is direct and unmistakable.

Ramsey sees acts of commission, which include physician-assisted suicide and euthanasia, as inimical to his theological perspective:

If we seriously mean to align our wills with God’s care here and now for [the dying], there can never be any reason to hasten them from the here and now in which they still claim a faithful presence from us.... This is the ultimate ground for saying that a religious outlook that goes with grace among the dying can never be compatible with euthanistic acts or sentiments.

All well and good, except for those who do not happen to share Ramsey’s theological point of view.

## Philosophy

In the second phase of the debate, philosophers and physicians weigh in, making many of the same arguments for and against physician-assisted suicide and euthanasia, but in more secular terms. Those in favor

emphasize considerations such as mercy in the face of unmitigable pain; self-determination in matters of life and death; and human dignity as residing in control over the manner and timing of one’s death. Some argue that there is no morally significant distinction between passively letting die and actively hastening death; that sometimes killing is morally justifiable; that society should determine the ethos of medicine; that this is essentially a private matter; and that legalization can ensure that there are constraints on the practice of physician-assisted suicide and euthanasia.

Those opposed hold the opposite to be true: that terminal pain can always be managed; that our lives are to be held in trust and that we do not have the authority ultimately to dispose of them; and that human dignity is to be found in the acceptance and transformation of suffering. They counter the protagonists’ arguments that there is no moral difference between passively letting die and actively hastening death, and urge that killing is intrinsically evil; they hold that medicine has values independent of those of society; that, far from being a private matter, the practice of physician-assisted death has public implications; and that the danger of the “slippery slope” is actually increased with legislation.

This is not the place to offer a critique of these assumptions. I take the most salient points to be the following: on the pro side, the argument from autonomy or self-determination, as well as the claim that it is the physician’s duty to alleviate suffering; and on the con side, the counter-claim that killing is contrary to the inherent ethos of medicine and warnings about the “slippery slope.”

Margaret P. Battin speaks eloquently for those in favor of physician-assisted suicide, arguing that the patient has not only the negative right to self-determination but also the positive right to assistance from a physician (Battin MP, “Physician Assisted Suicide and Opt-Out Conscience Clauses: Is a Physician Ever Obligated to Help?”, unpublished manuscript). The patient, she holds, has “a negative right not to be interfered with—that is, to be free to commit suicide if he or she wishes.” No longer do the theological concepts of stewardship and of theonomy (as distinct from autonomy) function as constraints—Battin sees human beings as fully emancipated, answerable to no one but themselves. Physicians, she argues, to whom alone society has entrusted custody of the means of ensuring a good death, have a positive duty to help those terminally ill patients in intractable pain who wish to die—a duty grounded in the bioethical principles of beneficence and non-maleficence. Alleviating suffering is an obligation deriving from these principles; mercy would require the physician to assist in the suicide of a patient whose suffering cannot be alleviated by pharmacological or other means.

Thinkers such as John Harvey,<sup>4</sup> for example, take the opposite view, as do Leon Kass, Willard Gaylin, Edmund Pellegrino, and Mark Seigler.<sup>5</sup> They aver that assisted suicide and “mercy killing” are contrary to medical tradition and medicine’s internal morality. All appeal to the

Hippocratic Oath and the codes of ethics of the American Medical Association, the American College of Physicians, and the World Health Organization. All are concerned that the nature of the physician-patient relationship will be irrevocably altered for the worse if physicians are given a license to kill. And all are troubled by the potential “slippery slope”—especially in light of reports from the Netherlands that the line is commonly crossed between “voluntary” and “involuntary” euthanasia, between competent adults and incompetent children, and between considering life overly burdensome to oneself and having one’s life considered overly burdensome to others.<sup>6</sup> Furthermore, those opposed to physician-assisted suicide (PAS) point out collectively, the logic of the Fourteenth Amendment to the US Constitution would surely dictate that a right given to the terminally ill, competent adult, in unmitigable pain should also be extended to those not terminally ill, the incompetent, and those whose pain was potentially manageable but who had tired of life. This is a point of particular concern to the disabled, who for years have been warning against the dangers of the “slippery slope.”

### Public Policy

Two recent federal court rulings (from the Second and Ninth Circuit Courts of Appeal) have created a de facto constitutional right to the assistance of a physician in committing suicide in certain circumstances. The rulings have been appealed to the Supreme Court, which should hand down its judgment this summer.

In two recent articles in *The New England Journal of Medicine*, David Orentlicher and George Annas make arguments respectively for and against the courts’ decisions.<sup>7,8</sup> Orentlicher argues, as Fletcher and others have done, that there is no moral difference between assisted suicide and the withdrawal of treatment: “... the relevant issue is whether the person is dying and beyond help, not whether the person dies as a result of treatment withdrawal or suicide.” He proposes that “if we view physicians fundamentally as relievers of discomfort or disease, with health promotion as part of that role, then assistance with suicide is not only compatible with the physician’s role but quite possibly an obligation inherent in it.” And he applauds the courts for “redefining the right to die to include a right to assisted suicide for terminally ill persons,” because in so doing they “have brought society’s legal rules more in line with society’s moral reasoning.”

Annas, indicating how overly sanguine Orentlicher is in thinking that “society’s moral reasoning” unanimously supports the courts’ rulings, speaks for many whose moral reasoning leads them in a different direction. He is concerned about the “slippery slope.” He fears that “If states adopt ... regulations [requiring such protections as second opinions and reporting], the hard-won rights that the great majority of patients can and do now exercise to refuse medical treatments are put at risk, since mandatory procedural safeguards can actually frustrate rather than foster the self-determination of patients.” He also

criticizes the Ninth and Second Circuit Courts of Appeals for “ignoring the past two decades of jurisprudence concerning the right to refuse treatment” and for “failing to make such basic distinctions as those between the right to refuse treatment and the right to die, between suicide and assisted suicide, between law and ethics, and between ends and means.”

By far the most powerful and compelling critique of legalizing PAS comes from Daniel Callahan and his co-author, Margot White, in a recent *University of Richmond Law Review* article.<sup>8</sup> They examine the provisions of bills pending in twelve state legislatures, as well as the Oregon statute that was passed in 1994. In an afterword, they also examine the rulings of the Ninth and Second Circuit Courts of Appeals. Since it seems likely that we in California will be attempting to develop consensus guidelines for aid-in-dying (should the Supreme Court hand this issue back to the state legislatures, as I expect it will), it is important that we heed Callahan’s and White’s critique of various safeguards that have been proposed.

They look at seven: consent; mental competence or decisional capacity; voluntariness; restrictions on eligibility; witnesses; definitions of abuse; and reporting requirements. (To these, I would add three others: how morally to differentiate “terminal illness” from a chronic, nonterminal but debilitating condition such as multiple sclerosis; how to identify and manage unmitigable pain and intolerable suffering; and the role, if any, of hospital ethics committees in reviewing requests for physician-aid-in-dying.)

*Consent.* Callahan and White conclude this section of their paper as follows:

Legislation itself cannot enhance the quality of an informed consent process that depends on the individual skills of the physician, that varies from situation to situation, that involves idiosyncrasies of patients, and that takes place in private. Legislation can require that informed consent be an element of the decision, that it be voluntary, and even that some other procedural steps should be required. However, the procedural steps for consent and information sharing specified in PAS legislation do nothing to cure the inherent indeterminacy of capacity and voluntariness.

*Mental competence or decision-making capacity.* Competence, for Callahan and White, “is a value-laden label that only pretends to scientific objectivity.” Further,

Competence and capacity are ultimately in the eyes of the care provider and are subject to the shifting sands of societal norms and values as much as individual values. At best, these concepts provide a minimal threshold standard, below which the patient’s choice would be reasonably denied because the patient is clearly not capable of making the decision. At most, the statutes can only

exhort the physician to ascertain some evidence of appreciation of the information provided, the nature of the decision, and the nature of its consequences. In the end, it is a professional judgment call ... about a legal criterion which the physician has no particular expertise in ascertaining. To say that this constitutes a safeguard on the practice of PAS would seem to be stretching the point.

*Voluntariness.* Callahan and White claim that "this concept turns out to be even more vacuous and maleable than competence or capacity." They write,

Autonomy is compromised by the fact of illness, hospitalization, and all the attendant anxiety and stress of the medical environment and medical interventions. In particular, terminal illness would seem to render autonomy and voluntariness more limited in practice than its idealized vision suggests. This does not mean that a practice such as PAS or euthanasia should be nonvoluntary. On the contrary, it serves to reaffirm our view that legislative assertions that the decision must be voluntary neither guarantee voluntariness nor provide any means to assess it in practice other than by the existence of a recorded request from the patient.

*Restrictions on eligibility.* "Proponents of PAS and euthanasia," write Callahan and White, "have always promised that legislation authorizing the practice would specify narrowly restrictive eligibility criteria as a central safeguard against indiscriminate, involuntary, or widespread use of the authority." The two most common restrictions are "terminal illness" and a life expectancy of six months or less. Callahan and White object that "terminal illness" is difficult, if not impossible, to define, and that predicting life expectancy is a guessing game. They dismiss restrictions on eligibility as unworkable.

*Witnesses.* "One of the arguments proffered by supporters of legalization," write Callahan and White, "is the claim that physicians currently practice assisted suicide and euthanasia in secret and therefore the potential for abuse is magnified by the lack of witnesses, records, and monitoring." The authors' extensive review of proposed legislation indicates that

witnesses will be present only at the time of writing and/or signing a written directive asking for physician-assisted suicide or euthanasia. They will not be present for any conversations between the physician and the patient, during any of the consultations, or during the informed decisionmaking process. In theory, witnesses are meant to provide some sort of oversight about the patient's state of mind and reassurance about the lack of undue influence and other improprieties. Indeed, witnesses appear to be subjected to more stringent qualifications in some of the bills than are patients.

In some of the proposed legislation, one of the two witnesses suggested may be not only a relative but also

the primary beneficiary of the patient's life insurance. In other proposed bills, there is nothing to prevent a complete stranger from attesting to the patient's soundness of mind after being assured of his or her identity by means of a driver's license.

*Definitions of abuse.* "Michigan's proposed statute," according to Callahan and White,

is wide open in terms of eligibility, and allows euthanasia as well as PAS. The statute, however, does attempt to identify what constitutes abuse: nonvoluntary euthanasia, forging or falsifying a directive, coercion, and concealing or ignoring a revocation of a directive. But since there are no witnesses to the writing and signing of the directive requesting euthanasia, and assisted suicide does not require any witnesses, and since there are no reporting requirements of any kind, where is the oversight or accountability, or monitoring of the process? Where, indeed, are the safeguards?

*Reporting requirements.* After reviewing the proposed legislation in each of the states considering legalization as public policy, Callahan and White conclude,

Oregon's statute and all of the other bills appear to provide blanket immunity from civil liability, criminal prosecution, or professional discipline for anyone who in good faith participates in, observes, or carries out the prescription of a lethal medication. Coupled with the absence of meaningful reporting requirements and the ongoing protection of privacy and confidentiality, legalization of PAS offers no remedy for secrecy, no safeguard against abuse, and no limitation on the potential universe of eligible patients.

I believe that Callahan's and White's opposition to physician-assisted suicide is magnificently one-sided. Their critique is of pending or present legislative safeguards; it does not consider those, more ethical than legal in nature, that institutions and professional organizations might devise.

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Let me end with a brief statement of where I stand. In physician-assisted suicide, I confront a genuine dilemma. On the one hand, I have enormous empathy for those rare individuals, terminally ill and in truly unmitigable pain, who ask for the help of a physician to enable them to end their lives. These are the individual cases in which I believe physician-assisted suicide to be a morally responsible act, both of the compassionate care giver and of the suffering patient. I deplore the fact that in such circumstances the physician has to act covertly and illegally.

On the other hand, I am troubled by the compulsion to leap from individual cases in which PAS seems morally justifiable into the arena of public policy where PAS is sanctioned across the board. Such a public policy is potentially fallible. The danger of the "slippery slope" (which form of argument I typically regard with

the utmost suspicion) in this case is real: recent reports from the Netherlands verify the danger.<sup>6,10</sup> Therefore, should physician-assisted suicide be legalized in the United States, those of us who would like to develop ethically sound policies, procedures, and safeguards for institutions and professionals to prevent abuse would do well to take seriously the concerns raised by Callahan and White. For if we cannot meet their objections and surmount the obstacles they identify, the worst fears of those opposed to aid-in-dying are likely to be realized.

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